MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 19, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Public comment period #3

MR. HACKBARTH: We will now have a brief public comment period.

MS. DePARLE: We didn't have a chance yesterday to thank the staff for the work on the March report. But I just wanted to say that it was really well done. And maybe it's just because I've been through it now more than once but the process also, I thought, went very smoothly. And Sarah, in particular, facilitated that.

MR. HACKBARTH: Thank you for saying that.

MR. CALMAN: My name is Ed Calman. I'm general counsel to the National Association of Long-Term Care Hospitals.

I would like to again thank staff and the two commissioners, Nick in particular, that traveled around the country as part of the study. I think they were very diligent in what they did. They were only limited by the data and certainly not by talent or will to do justice by the issue.

I do have some comments which I'd like you to hear on the recommendations that I think are important.

I think that in going through this issue you should be keenly aware that some of these recommendations may create gaps in care. I'd like to go over that very briefly with you.

Some long-term care hospitals admit patients with respiratory failure that may not wean. They will give them a chance to wean. These are spinal cord injury cases, some strokes, but they give them a chance. Some long-term care hospitals do not admit that population.

For the long-term care hospitals that do admit that population a number of them fail and they are at the long-term care hospital. At that point they are usually not a Medicare liability. They are a Medicaid liability because they've used days in a spell of illness before they've gone to a long-term care hospital.

These patients use a lot of resources. It's not just nursing, it's deep suctioning which they do not get in nursing homes except in the state of California which does have very robust high intensive nursing home system because MediCal pays for that.

Some patients, even in California, can't go to a nursing home because of the adjustments that they need to the ventilator and the type of ventilator.

So I think that it's important that these hospitals be allowed to continue with their mission. This is not a matter of money because they are all outliers and long-term care hospitals lose money on outliers. And believe me, in most states most long-term care hospitals

lose money on Medicaid.

So I think that with respect to your recommendation that it ought to be that instead of that they cannot be treated in a nursing home, because I'm very familiar with theoretical leveling I call it, that a nursing home can do things, it should be that they cannot as a practical matter be treated in a nursing home in their locality.

Secondly, I think this rehabilitation issue is one that requires examination. There are long-term care hospitals that do comprehensive rehab, that is acute rehab. They admit the same patients that rehabilitation hospitals admit. And they have the resources to do that. Some of them are very well known in the United States.

They also admit medically complex cases. And if it's 50 percent, as Dr. Kaplan indicated, you know they cannot qualify to be a rehabilitation hospital because it has to be 75 percent. So they cannot be a rehabilitation hospital. And when their medically complex long-term hospital patients get better and can withstand three hours of rehab a day, they give it. They do not transfer to an IRF.

The Medicare program makes out on that deal. Those hospitals do not make out on that deal because they make less money and they have issues with their 25 day length of stay because a rehab case is a 14-day event. It's not a 25-day event.

I do understand and appreciate the issue raised about rehabilitation and I think a thoughtful way to approach that is to allow long-term care hospitals -- and I would put a bed minimum on it because there are larger long-term care hospitals, to have rehabilitation units. Currently CMS does not allow long-term care hospitals to have a rehabilitation sub-unit.

I would further recommend that once a case comes into that hospital that it's one payment, that they wouldn't be able to be transferred between a long-term care hospital unit and a rehabilitation hospital unit so we do not recreate problems and that it's bundled once they enter. It's bundled now. I'd like to keep it bundled. I think that that's appropriate with the proper payment.

Physician visits is also another problem. Patients admitted to long-term care hospitals are at a hospital level of care and they need daily physician visits when they enter. They do not need daily physician visits necessarily thereafter. Some hospitals organize themselves differently. We have head trauma cases in long-term hospitals, we have various types of cases in long-term hospitals. And a physician is there. A physician may have to intervene three times a week but not daily and physician extenders are used.

If the government was to require daily physician

visits, the government would get daily physician visits and Part B expenditures would go up. So I think you ought to be concerned about that.

I also think it's very important that you understand, on the issue of criteria, that QIOs and PROs before them were not funded to review long-term care hospitals. So while they did have screening criteria to screen the medical appropriateness of admissions, continued stays and discharges they did not exercise that authority.

CMS this year has opened the door a small bit by allowing, I think it's 1,400 cases to be reviewed. And QIOs are establishing criteria for long-term hospitals. Our organization clearly endorses that. We've made that known to Commission staff. And I think that many of the problems that are correctly perceived can be addressed into a good way by the QIOs because their process is one of medical screening criteria if a case fails a physician-to-physician review so that it is fair to the patient and fair to the provider.

I would also note, I was interested in the comment on budget neutrality. The PPS rules provide for a six-year look back and a budget neutrality adjustment. And you should know that. It's not defined as to whether that will account for volume. That is, increase in the number of cases. I think more about increase of cases that in the number of hospitals.

So that authority does exist and I would love to know how CMS is going to go about that calculation. Perhaps you could ask them how they're going to do that.

I would also like, you may or may not know that our association ran a study concurrent to the Commission's study which was conducted by Lewin Group. Many of the findings were the same. But there was one finding I'd like to point out. And that is that on one analysis it was found that Medicare beneficiaries that went to long-term care hospitals used acute hospitals less. I believe that statistic was 7.4 percent less utilization. And that would be important or should be thought about in terms of the financial analysis of these facilities.

We are also concluding a multicenter study with 23 hospitals, 1,400 patients on ventilator weaning, which will hopefully be published later this year or next year. And that is available to the Commission and we have shared that data with staff. So we have weaning rates in long-term care hospitals. We're not able to do a comparative study with acute hospitals.

I will say finally, I want to comment about APR-DRGs and the recommendation to use them. I am a lawyer but I have had to get to know something about coding. What I find out about APRs, as with DRGs, is that you do not know the code when the case enters because the coating is changed by comorbidity and procedures. And if you have a case with

respiratory failure, with ventilator support, it will get a severity level four with APR-DRGs. If you add a minor amputation of a finger, the surgical procedure is coded first and drops the severity of illness.

So if this is going to be used as a measure of certification for long-term care hospitals I would like staff to consider whether that's material. I do not know whether it's material, but it's certainly a reaction that I have to that recommendation.

Thank you very much for listening to me, and I look forward to your final recommendations in April.

Thank you.

MR. HACKBARTH: Okay, thank you very much.

We are adjourned.

[Whereupon, at 12:11 p.m., the meeting was adjourned.]